STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF NURSING

IN THE MATTER OF THE LICENSE OF	:	Administrative Action
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	:	
	:	
TINA FULMORE, R.N.	:	
License # 26NO 07925900	:	**FINAL ORDER**
	:	**OF DISCIPLINE**
	:	
TO PRACTICE NURSING IN THE	:	
STATE OF NEW JERSEY	:	

This matter was opened to the New Jersey State Board of Nursing ("Board") upon receipt of information which the Board has reviewed and upon which the following findings of fact and conclusions of law are made:

FINDINGS OF FACT

1. Tina Fulmore ("Respondent") is a Registered Professional Nurse (RN) in the State of New Jersey, and has been a licensee at all times relevant hereto.

2. On or about May 15, 2014, the Director of Human Services and Operations of VNA Home Care and Hospice of Mercer, Trenton, New Jersey, submitted a report to the Board pursuant to the Health Care Professional Responsibility and Reporting

Enhancement Act alleging that Respondent had engaged in professional misconduct. According to the report, Respondent documented a clinical visit for February 11, 2014 at a patient's residence, describing the patient, L.M., sitting on the bed, documenting vital signs, and the documentation included a patient signature.

3. The patient L.M., on the date and at the time reflected in the February 11, 2014 chart, was an in-patient at an acute care facility.

4. L.M. had been admitted into Capital Health of Trenton, New Jersey on February 10, 2014 at 3:52 p.m., and his discharge date was March 8, 2014, when he was pronounced dead.

5. Respondent was unable to explain how it was the she documented a home visit to patient L.M., assessed patient L.M., noted his vital signs, and obtained L.M.'s signature on a date when L.M. was indisputably not at home, as he had been admitted to a medical facility on the previous day, and remained at the facility until his death on March 8, 2014.

CONCLUSIONS OF LAW

Respondent's documentation of a home visit to L.M. on a date when L.M. was not present constitutes deception or misrepresentation in violation of N.J.S.A. 45:1-21(b), and professional misconduct in violation of N.J.S.A. 45:1-21(e).

DISCUSSION

Based on the foregoing findings and conclusions, a Provisional Order of Discipline seeking a two year suspension (one year active, one year stayed) was entered on July 16, 2015. Copies were served upon Respondent via regular and certified mail. The Provisional Order was subject to finalization by the Board at 5:00 p.m. on the thirtieth day following entry unless Respondent requested a modification or dismissal of the stated findings of fact and conclusions of law by setting forth in writing any and all reasons why said findings and conclusions should be modified or dismissed and submitting any and all documents or other written evidence supporting Respondent's request for consideration and reasons therefor.

Respondent replied to the Provisional Order of Discipline. She acknowledged that the record that she submitted regarding patient L.M. was inaccurate. In her response to the Provisional Order, Respondent maintained that she saw L.M. for a second visit before he went into the acute care facility and believed that she made an error in the date of the visit - that the visit actually occurred on February 8 or 9, instead of February 11. In a previous submission to the Board, Respondent maintained that she was assigned to multiple patients in the apartment building where L.M. lived and she did see a patient in that apartment building on February 11, thereby suggesting that she

made an error in the name and identity of the patient.[1]

Respondent argues that she had no incentive to document a home care visit that did not actually take place, but that belies the obvious reason - to get paid. Fraud occurs in the home care arena when nurses document and get paid for visits that they do not make.

The Board reviewed Respondent's submissions and determined that further proceedings were not necessary and that no material discrepancies had been raised. The Board was not persuaded that the submitted materials merited further consideration. Although Respondent argues that she merely made a mistake in documentation, her multiple entries on two separate documents is more than a simple mistake. Additionally, the gravity of her mistake (for example, the name and identity of the patient) rises to a different level.

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[1] In addition to the patient's electronic health record, Respondent documented that she visited L.M. on a form entitled "Activity Report" for February 11, 2014 claiming activity time and travel time for which she was paid. Although this information was received by the Board prior to the filing of the POD, it was not included therein and the POD was not based upon this information. Nonetheless, the Board has the information and the information supports the findings in the POD.

ACCORDINGLY, IT IS on this 14th day of December, 2015, **ORDERED that:**

1. Respondent's New Jersey nursing license is hereby suspended for a period of two years. One year of the suspension is to be actively served; with the remaining year of suspension to be stayed and served as a period of probation. The suspension is to commence on the first day of the first month following the filing of a Final Order of Discipline in this matter.

2. Two months prior to the termination of Respondent's active period of suspension, Respondent may petition the Board for reinstatement of her nursing license, and for the commencement of the period of stayed suspension.

3. Respondent shall refrain from practicing as a nurse and shall not represent herself as a Registered Professional Nurse until such time as her license is reinstated. Any practice in this State prior to reinstatement shall constitute grounds for a charge of unlicensed practice.

NEW JERSEY STATE BOARD OF NURSING

By: Patricia Murphy
Patricia Murphy, PhD, APN
Board President